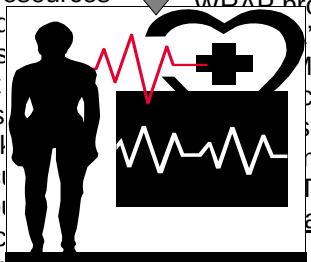
Consumer Council News

March 22, 2005 Volume 8, Issue 4

Wellness Recovery Action Plan

Mary Ellen Copeland developed the Wellness Recovery Action Plan (WRAP) in 1997. This approach is now a highly recognized tool that supports recovery. WRAP leads people through the process of (1)identifying their strengths and resources (2)figuring out what they need to d day to stay feeling as well as poss identifying things that might upset which Wellness Tools they can us them get through this difficulty (4)k when they are having a very difficu and things they can do to get throu time and (5)developing an advanc tive that tells others what to do for they can no longer care for thems WRAP and the mental health reco riculum are being used in many VA medical facilities and it is being reviewed for the veterans and family members of returning Iraq and Afghanistan soldiers to promote rehabilitation and recovery. WRAP offers enhance opportunity for prevention, the identification and use of simple, safe self care strategies, and improves the effectiveness of mental health services. The WRAP program has been recognized by 's Center for Mental Health Services (CMHS) as an exemplary practice. cy has been studied by the states sota and Vermont and it is curng studied in Connecticut and To learn more visit: www.althrecovery.com



We Care About Our Veterans

Budget Woes

The President's proposed budget for 2006 allocates a total $70.8 billion for VA. There is an $111 million increase over the total amount spent on VA medical care in 2005 which represents an increase of less than one half of one per cent. Included in the proposed budget is a $250 user fee from Category 7 and 8 veterans and an increase in pharmacy co-payments. The budget proposes to revise eligibility criteria for long-term care services. The new criteria would limit eligibility to only those injured or disabled while on active-duty; those catastrophically disabled; patients requiring short-term care subsequent to a hospital stay ;and those needing hospice or respite care. To coincide with this legislative proposal, the budget decreases funding for care of VA residents in nursing homes, contract nursing homes and state nursing homes by $351 million. Secretary Nicholson described in the hearing a four-pronged approach by VA to make the ends of the budget meet through new management efficiency initiatives, and increase in collections from third-party insurers, the new revenue collected from the enrollment fee and increased pharmacy fees, and the redefinition of eligibility for long-term care services.

The VA Network Directors are preparing for budget constraints in the coming year.

Transition Focus

A new subcommittee of the House Veterans' Affairs Committee will focus on veterans' transition to civilian life. Chairman Steve Buyer stated "While a disabled veteran's life has changed, our responsibility is to see that they have the opportunity to live beyond government assistance." This subcommittee will have jurisdiction over veterans' education, vocational rehabilitation, housing programs, readjustment to civilian life and civil relief.
Learn more at: www.veterans.house.gov

Newsletter sponsored by VA Mental Health Consumer Council
FAX comments to Lucia Freedman at 202-273-9069 or call 202-273-8370

Online Newsletter
www.mentalhealth.med.va.gov/cc

Questions about Mass Screening of Military Personnel

In a recent commentary in JAMA "Screening for Psychological Illness in Military Personnel" (March 9, 2005) there was caution advised to mass screening. There have been calls for widespread screening of members of the armed forces to identify those at risk of future psychiatric injury before deployment and to identify those with psychological problems on their return home. The study pointed out that this was done during World War II and it was a failed effort. In this instance 2 million men had been rejected only to find later than many reenlisted and the majority were satisfactory soldiers. The article points out that there is a low yield of clinically important conditions identified through military screening questionnaires. For instance the PTSD checklist was thought to be inefficient because the percentage of service personnel needing prompt medical or psychological support was low in comparison with the high percentage of soldiers with screen positive test results.

Most surveys in the armed forces show a low response rate. When a soldier returns from deployment the main motivation is to answer questions in a way that reduces any chance of delaying their leave. It is likely that current predeployment and postdeployment questionnaires underidentify psychological problems. Overestimation of illness may sometimes occur because of overreporting symptoms when soldiers return home, perhaps influenced by the desire to access health care after leaving the services. The commentary pointed out that is not easy to assess the validity of the written psychological tests on which mass screening is based. There is also the stigmatization of veteran's health that could effect employment in civilian life and interactions with family and friends. The commentary recommendations are to improve support structures for veterans and service personnel within and outside the military organization and improve recognition and management of health problems in an atmosphere of confidentiality.

Drop in Group Medical Appointments

A new initiative being tried in VA Medical Facilities, the Drop in Group Medical Appointments (DIGMAs) is showing evidence that patients with various different chronic diseases can benefit from group clinics. This model has been studied for diabetes care in primary care clinics and has gotten high satisfaction ratings from patients. This model is now being talked about for other chronic diseases. The basis of the model is to give patients a better understanding of the disease process and how they can improve outcomes by making different behavioral and therapeutic choices.
In a typical model the professionals are the experts who tell patients what to do and the patients are passive. In the DIGMA model there is a shared expertise with active patients. Professionals are experts about the disease and patients are experts about their lives. There is a shared responsibility for solving problems and for outcomes. The model encourages the patient to set goals and the professional helps the patient make informed choices. If a goal is not achieved then the partnership between the patient and the professional looks at modifying strategies so reaching the goal can be successful. In the traditional care model behavioral change is external but the collaborative care model emphasizes internal motivation. Patients gain understanding and confidence to accomplish new behaviors. There is a transfer of problem solving strategy so that the professionals teach problem solving skills to help patients in solving problems as opposed to the professional solving the patients problem.
The group clinic saves time, reduces waits and improves patient satisfaction and self-management. This may have promise for the future as a way to help patients with chronic physical and mental illnesses.

Information and Resources

May 31-June 3,2005
National Coalition for Homeless Veterans
Capital Hilton Hotel
Washington, D.C.
202-546-1969/800-VET-HELP

June 9-11, 2005
"Justice for All", 2005 National Mental Health Association Annual Conference
Hyatt Regency Washington
Washington, D.C.
www/nmha.org